ORTHOPEDIC MEDICAL REPORT
P-142OR REV. 5-2001

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
MEDICAL REVIEW DIVISION
On The Web At http:// dmvct.org

TO: Department of Motor Vehicles, Medical Review Division, 60 State Street, Wethersfield, CT 06161-2510

PATIENT'S NAME	DATE OF BIRTH	TELEPHONE NO.

ADDRESS	WHEN WAS PATIENT LAST EXAMINED BY YOU?

IS THIS A PROGRESSIVE *(DETERIORATING)* ILLNESS? ☐ YES ☐ NO	IF YES, COMMENT AS TO PROGRESS
ARE THERE SPLINTS OR APPLIANCES THAT SHOULD BE WORN WHILE PATIENT IS OPERATING A MOTOR VEHICLE? ☐ YES ☐ NO	IF YES, SPECIFY
DO YOU BELIEVE PATIENT UNDERSTANDS THE SIGNIFICANCE OF HIS/HER DISORDER? ☐ YES ☐ NO	DO YOU BELIEVE PATIENT IS COMPLIANT IN REGARDS TO PRESCRIBED MEDICATIONS? ☐ YES ☐ NO

ABNORMALITIES ON ORTHOPEDIC EXAMINATION

OF WHAT OTHER RELEVANT MEDICAL OR SURGICAL HISTORY ARE YOU AWARE? *(Use additional sheet of paper if necessary)*

HISTORY OF ANY DISORDER RELEVANT TO SAFE OPERATION OF A MOTOR VEHICLE *(Very brief outline)*

Does this person have a deteriorating condition? ☐ **YES** ☐ **NO** **If yes, specify condition and indicate how often he/she should be re-examined.**

IN YOUR OPINION, SHOULD THE DMV PERMIT THIS INDIVIDUAL TO HOLD AN UNLIMITED OPERATOR'S LICENSE? ☐ **YES** ☐ **NO**

If no to question above, would this individual be safe to drive with certain restrictions? ☐ **YES** ☐ **NO** **If yes, please elaborate**

PHYSICIAN'S NAME *(Please Print or Type)*	OFFICE ADDRESS *(Include Zip Code)*

TELEPHONE NO.	PHYSICIAN'S LICENSE NO.	PHYSICIAN'S SPECIALTY

PHYSICIAN'S SIGNATURE	DATE REPORT COMPLETED
X	